

# 2011 Military Health System Conference

## TRICARE: A Regional View

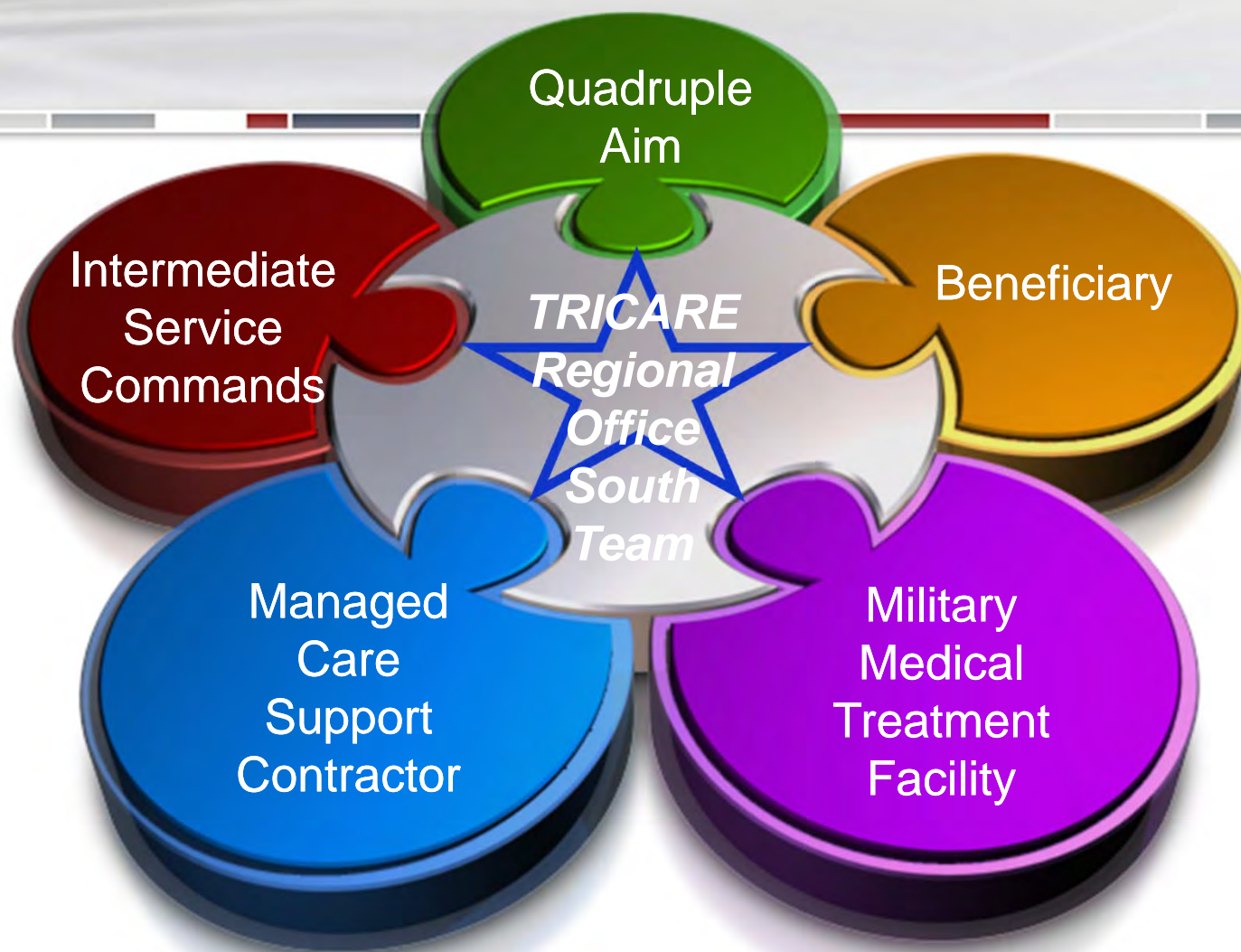
*The Quadruple Aim: Working Together, Achieving Success*

Mr. William Thresher MA, CHIE

24 January, 2011



Report Documentation Page				Form Approved OMB No. 0704-0188	
Public reporting burden for the collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to a penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.					
1. REPORT DATE <b>24 JAN 2011</b>		2. REPORT TYPE		3. DATES COVERED <b>00-00-2011 to 00-00-2011</b>	
4. TITLE AND SUBTITLE <b>TRICARE: A Regional View</b>				5a. CONTRACT NUMBER	
				5b. GRANT NUMBER	
				5c. PROGRAM ELEMENT NUMBER	
6. AUTHOR(S)				5d. PROJECT NUMBER	
				5e. TASK NUMBER	
				5f. WORK UNIT NUMBER	
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) <b>Military Health System, TRICARE Management Activity, 5111 Leesburg Pike, Skyline 5, Falls Church, VA, 22041</b>				8. PERFORMING ORGANIZATION REPORT NUMBER	
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)				10. SPONSOR/MONITOR'S ACRONYM(S)	
				11. SPONSOR/MONITOR'S REPORT NUMBER(S)	
12. DISTRIBUTION/AVAILABILITY STATEMENT <b>Approved for public release; distribution unlimited</b>					
13. SUPPLEMENTARY NOTES <b>presented at the 2011 Military Health System Conference, January 24-27, National Harbor, Maryland</b>					
14. ABSTRACT					
15. SUBJECT TERMS					
16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT <b>Same as Report (SAR)</b>	18. NUMBER OF PAGES <b>22</b>	19a. NAME OF RESPONSIBLE PERSON
a. REPORT <b>unclassified</b>	b. ABSTRACT <b>unclassified</b>	c. THIS PAGE <b>unclassified</b>			



Proudly serving the Military Health System as an *action agent*, pursuing value, while ensuring the efficient and quality delivery of healthcare.



# We Make a Difference



# TRICARE - Who We Are



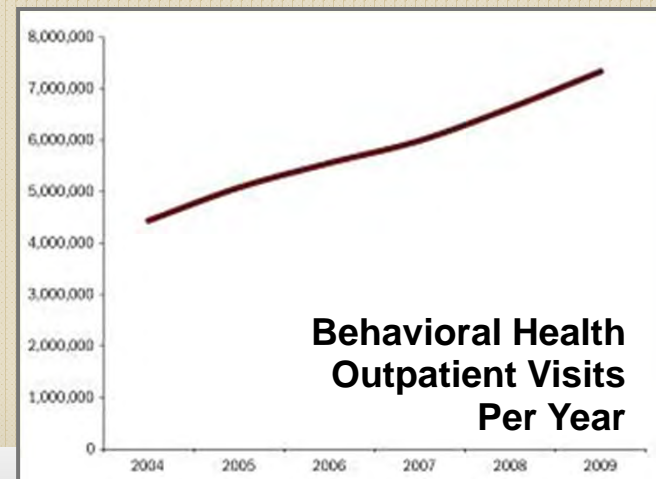
- 9.6 million beneficiaries **3.0 million in South**
  - 3.7 million TRICARE Prime enrollees (*direct care system*) **1.0 million in South**
  - 1.6 million TRICARE Prime enrollees (*contractor networks*) **0.6 million in South**
- MTFs include 59 hospitals & medical centers and 364 health clinics
- Over 380,000 participating providers  
**116,000 participating providers in South**
- Over 60,000 retail pharmacies
- TRICARE annual cost per beneficiary (FY09)
  - Prime: \$4,202
  - Standard: \$3,584
  - TFL (age 65+): \$3,874  
(*does not include Medicare contribution*)





# A Week in the Life of TRICARE

- **21,800 inpatient admissions**  
*(7,800 South)*
  - 5,000 direct care
  - 16,800 purchased care
- **1.6 million outpatient visits**  
*(577,300 South)*
  - 737,000 direct care
  - 876,400 purchased care
- **2,300 births** *(648 South)*
  - 1,000 direct care
  - 1,300 purchased care
- **3.5 million claims processed**
- **12.6 million electronic health record messages**
- **2.5 million prescriptions**  
*(968,000 South)*
  - 923,000 direct care
  - 1.39 million retail pharmacies
  - 202,000 home delivery
- **179,300 behavioral health outpatient services**
  - 46,100 direct care
  - 133,200 purchased care



# Our Burning Platforms



## **“Health care: The thing that ate the Pentagon”**

By Tom Philpott, Special to Stars and Stripes  
Pacific edition, Saturday, April 18, 2009

1. “Gates said, the department is to spend \$47 billion in health care in 2010, costs that are “eating the Department alive.”
2. “Gates...gets a “very different story from every soldier, sailor, Marine and airman that I talk to” and from military spouses, Gates said. Common complaints range from delays in getting appointments to Routine bureaucratic hassles to difficulties getting referred to medical specialists.”

# Our Burning Platforms



## **“Gates Gives Brutal Assessment of TRICARE”**

By Kevin Baron. Stars and Stripes, Sept 04, 2010

1. Defense Secretary Robert Gates launched into a brutal assessment of the military's health care system, TRICARE, this week, calling it a constant source of complaints from troops and badly in need of financial reform in the face of rapidly increasing cost estimates to the federal government.
2. “I get briefings at the Pentagon all the time about how popular TRICARE is and how everybody's happy with it,” Gates responded. “Well, I tell you, I've been on this job going on four years and I've visited a lot of folks, a lot of facilities, a lot of ships, a lot of air bases and I have yet to find somebody stand there and tell me this is a great system.”

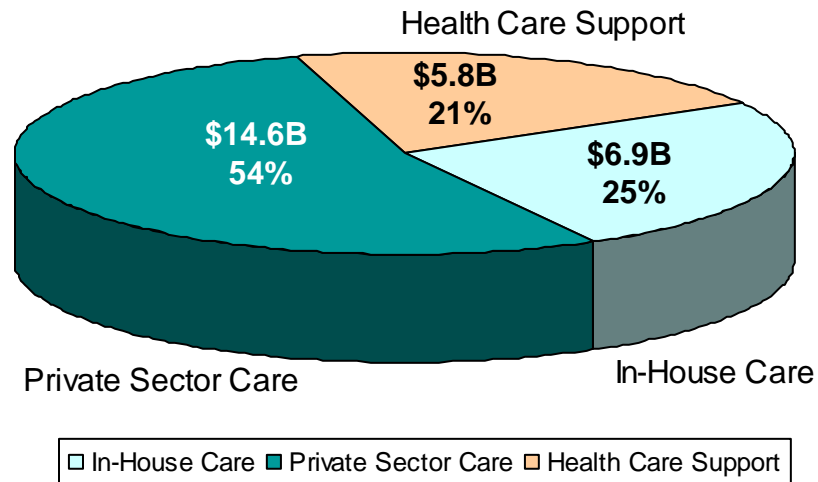


# Defense Health Program

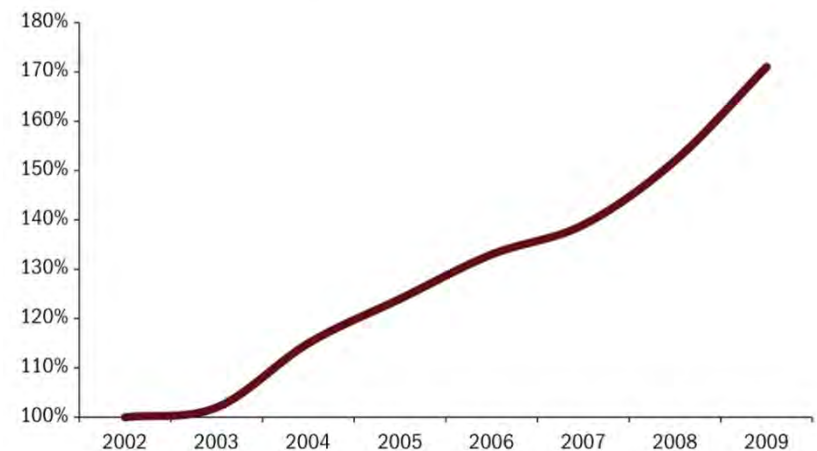


## Operations and Maintenance Budget with PMPM Expense Curve

**FY10 Defense Health Program Budget  
(Operations and Maintenance)**



**Per Member Per Month Expense  
(Trend with 2002 as Baseline)**



— MHS Per Member Expense

Data Source: Defense Health Program FY10 Appropriation.  
Excludes all costs associated with the Medicare Eligible Retiree  
Health Care Fund – e.g. \$3.8B TRICARE Senior Pharmacy

# Why is Healthcare Cost Growing?



## INCREASED NEW USERS

- Since 2007, the number of beneficiaries has increased by 400,000

## EXPANDED BENEFITS

- TRICARE For Life, Rx benefits, Reserve Benefits, TBI-PH

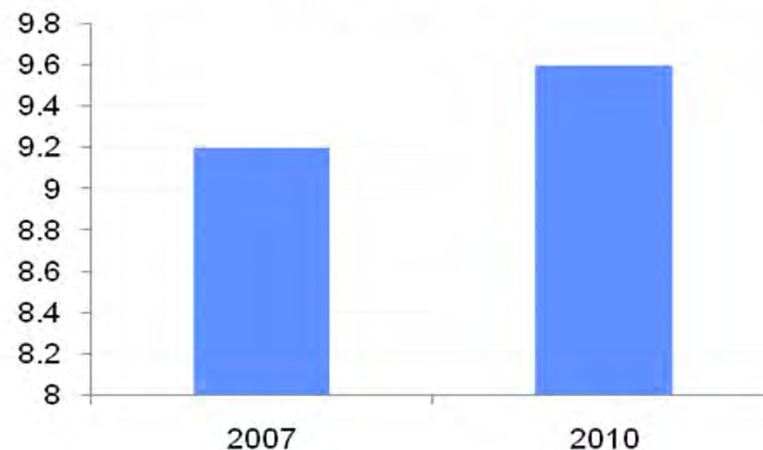
## INCREASED UTILIZATION

- Existing users are consuming more care (ER, Orthopedics, Behavioral Health, PT)

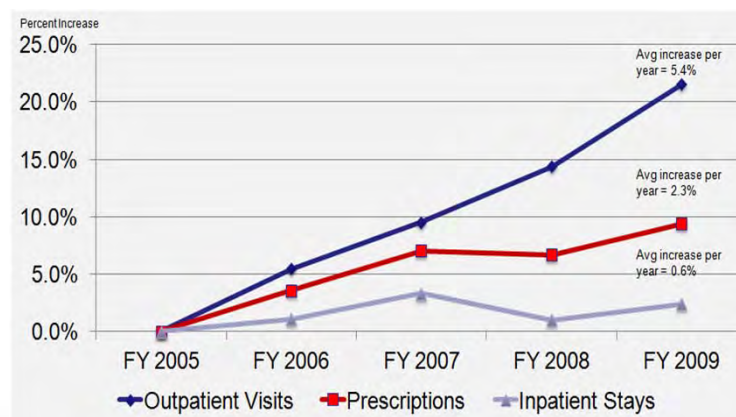
## HEALTHCARE INFLATION

- Higher than general inflation rate
- Consistent with civilian healthcare sector

**Beneficiaries**  
(millions)



**MHS Healthcare Utilization Trends**



# Other Reasons for Cost Growth



- **Perversely Incented Caregivers**
  - Fee-based, piecework, uncoordinated, volume-incented, consumer-insulated, payment system
  - Many treat – few prevent
- **Limited Performance Data (Data is the Special Sauce)**
  - Data isn't shared
  - Hidden variability in performance and costs
- **Inefficient, Uncoordinated, Unlinked Care**
  - Limited money, tools, no accountability for linkages
  - Selling pieces of care, instead of packages of care
  - Chronic care linkage deficiencies drive significant health care costs
- **New Technology, New Treatments, New Drugs, New Science**
  - 40% of health care cost increases come from new approaches (CBO)
  - Few standards of value



# Addressing Cost Growth on All Fronts



## REDESIGN DIRECT CARE

- Patient-Centered Medical Home – new model to improve access, drive appropriate utilization
- Integrate behavioral health services into Medical Home

## RE-ENGINEER PURCHASED CARE

- Implement / streamline new TRICARE contracts (T3)
- Design new approach to TRICARE contracts (T4)

## ADDRESS BENEFIT ISSUES

- Introduce more aggressive market-based pricing initiatives
- Redirect pharmacy to lower cost venues; reduce ER utilization

## REALIGN ORGANIZATIONAL MODEL

TBD

*Complete Implementation of Other Required Initiatives that Transform MHS*

## ELECTRONIC HEALTH RECORD WAY AHEAD

- Develop/enhance enterprise electronic medical record
- Enhanced clinical support from theater thru garrison
- Assured sustainment, stabilization and availability
- Develop DoD/VA part of Virtual Lifetime Electronic Records (VLER)

## BRAC COMPLETED (SEPTEMBER 15, 2011)

- Close two major medical centers in Washington, DC and San Antonio; renovate other major medical centers and open premier community-based hospital in the US
- Open Joint Medical Education & Training Center
- Co-locate OSD(HA), TMA, and Service Surgeons General in single location

Separate from this proposal regarding organizational efficiency, Health Affairs has put forward a number of initiatives with more than \$7 billion in cost reductions over the FYDP as part of the Front End Assessment

# Addressing Cost Growth Now



**THE ANSWER IS DELIVERING CARE MORE EFFICIENTLY AND EFFECTIVELY**

## **Begin with Goals**

- **Big, specific, clear, unambiguous, focused, meaningful goals**
  - **Example: Cut crisis-level hospital admissions needed for asthma patients in half in two years**

## **Adjust Incentives**

- **Target desired behaviors for both providers and beneficiaries**

## **Improve Data Availability and Usage**

## **Use Connectors**

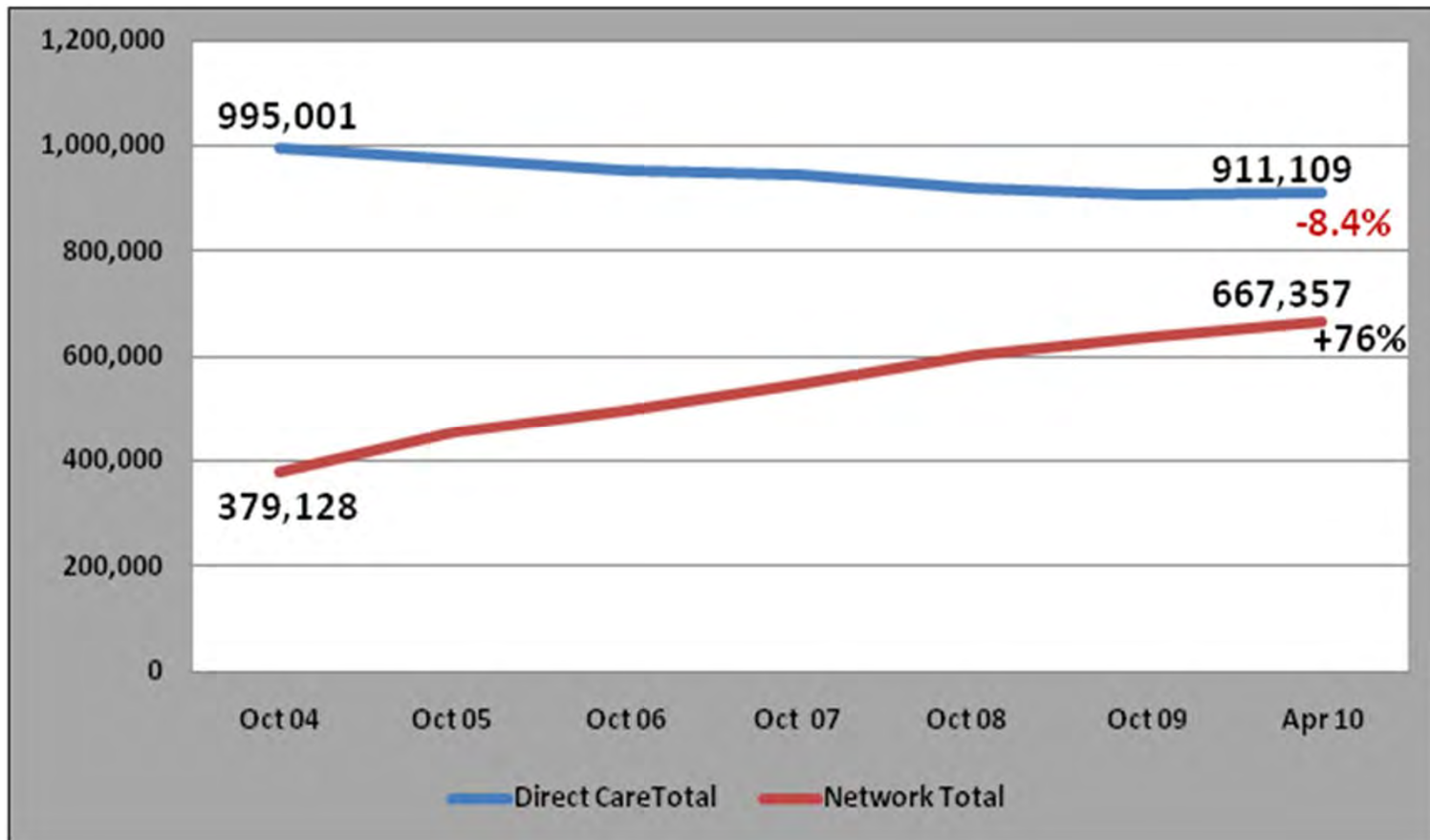
- **Care coordination deficiencies add cost**
  - **80% of health care costs come from 10% of the patients**

## **Encourage a Culture of Health**

## **Get Started Now With the Tools We Have**

# South Region Enrollee Trend

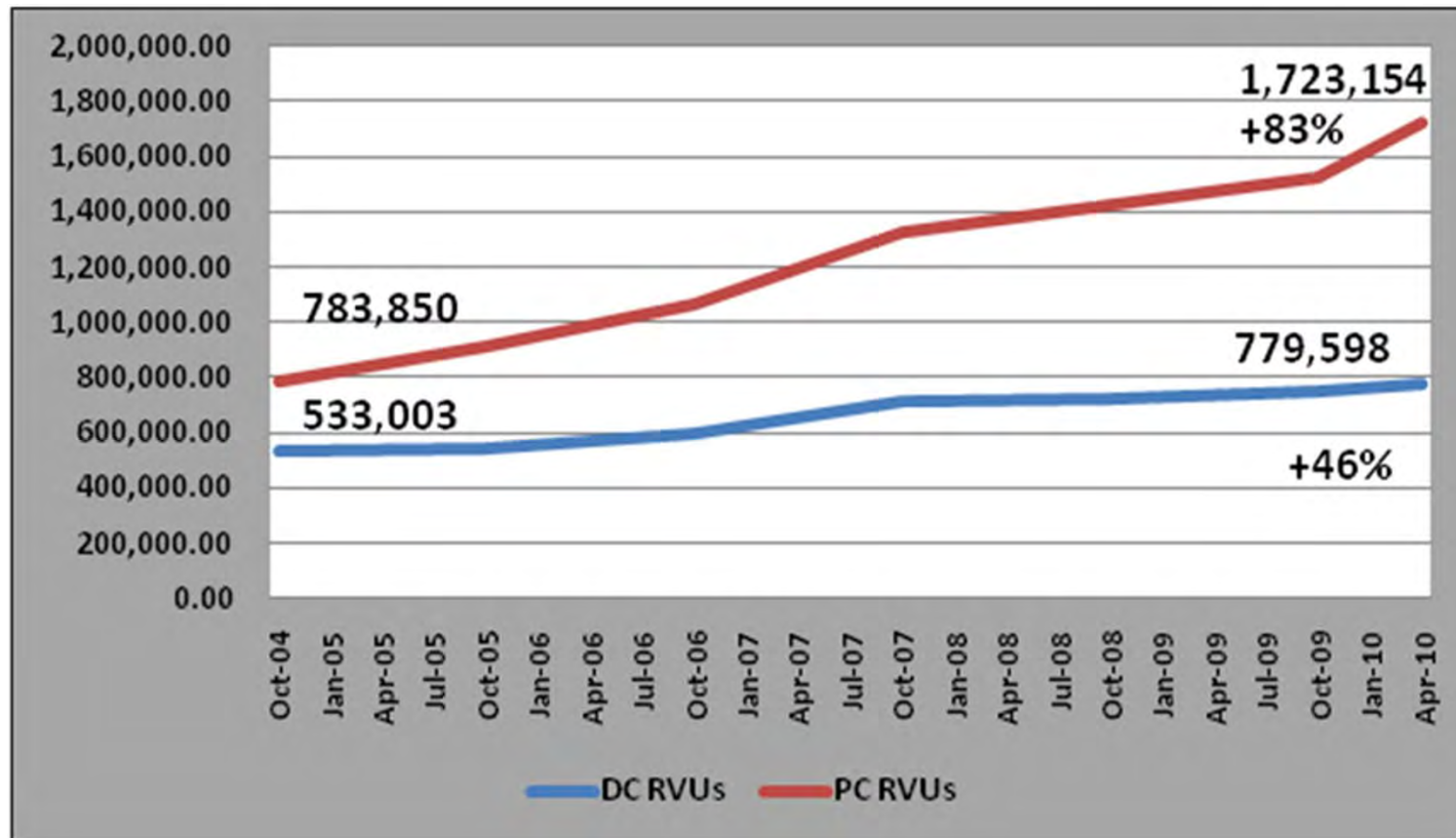
## Oct 04 – Apr 10



Source: M2



# South Region Enrollee RVU Trend Oct 04 – Apr 10



Source: M2

# One Region's Focus Areas for 2011



- Supporting the War fight
- T-3 Transition
- Wounded Warrior Programs
- Quadruple Aim and PCMH
- Optimized Community Based Health Care
- Strategic Communications
- Focused Support of Network Prime Population
- Support for National Guard/Reserve (TRS)
- Support for TRICARE Standard and Extra
- Access, Quality, Satisfaction, Cost, Value
- Improved Population Health Performance
- Network Provider Relations

**Sustain Excellence**

**Make a Difference**

*\*All supported by better use of data*

# Optimizing Community Based Health Care Delivery



DoD needs a strategy for health care delivery that integrates the direct care system and the contracts supporting DoD health care delivery. Lack of integration diffuses accountability for FISCAL management, results in misalignment of incentives, and limits the potential for continuous improvement in the quality of care delivered to beneficiaries.

Task Force on the Future of Military Health Care





# Why Optimized Communities are Important

- Effective MHS Integration
  - Better Leverages Sunk Costs/latent Capacity
  - Optimizes Military Medical Readiness
  - Fixes accountability for Fiscal Management
  - Improves Human Capital Management
  - Provides Better Value
  - Enhances Potential for Continuous Improvements in quality of care
  - Is More Efficient and Equitable

# Community Optimization

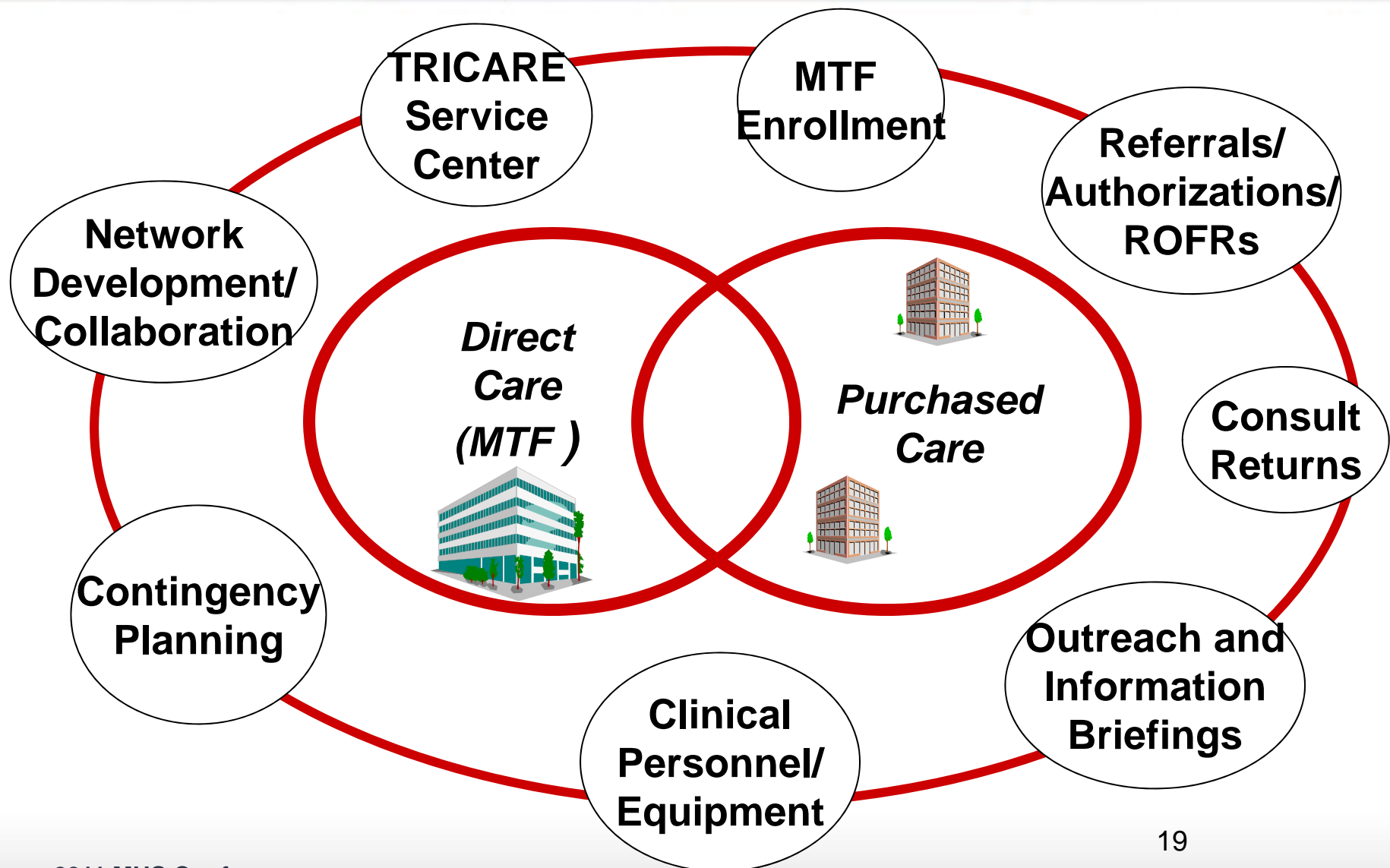


**Filling Every Appointment and Bed Available Within the MTF with the Appropriate Patient Based on the Capacity and Capabilities of the MTF and the MTFs Readiness/Training Requirements.**

TRICARE Operations Manual.

**Today's focus must be on opportunities to leverage the network in support of the MTF base to optimize community based health care delivery**

# Integration at the Operational Level





# The MHS Opportunity to Set an Example for the Nation



- Goals of US Health Insurance Reform:
  - No discrimination for pre-existing conditions
  - No exorbitant out-of-pocket expenses, deductibles or co-pays
  - No cost-sharing for preventive care
  - No dropping of coverage for seriously ill
  - No gender discrimination
  - No annual or lifetime caps on coverage
  - Extended coverage for young adults
  - Guaranteed renewal despite illness



*Based on the President's Health Insurance Consumer Protections*

[www.whitehouse.gov/health-insurance-consumer-protections/](http://www.whitehouse.gov/health-insurance-consumer-protections/)



*“It is never too late to be what you might have been” -George Eliot*

*“To really listen with your heart takes tremendous courage, especially when it is about you, and the message is critical of you.”*

*-Kirtland Peterson*



Mr. William Thresher  
[William.Thresher@TROS.tma.osd.mil](mailto:William.Thresher@TROS.tma.osd.mil)